TRAVELER'S MEDICAL SERVICE INFORMATION

PERSONAL DATA (please print clearly)

Name:	Phone No.:
Address:	Date of Birth:
Emergency Contact Name:	Phone No.:

TRAVEL INFORMATION
List all travel dates and countries in order of dates traveling:

Date	From	To	Length of stay

Reason for Travel: ☐ Business ☐ Tourist ☐ Student ☐ Missionary ☐ Other_____

Accommodations: ☐ Hotel ☐ Family/friends home ☐ Cruise ☐ Other_____

Do you plan to visit only tourist's areas or major cities? ☐ YES ☐ NO

Do you plan to visit rural areas? ☐ YES ☐ NO

Do you plan to visit rural areas during evening/nighttime hours? ☐ YES ☐ NO

Do you plan to travel to high altitudes? ☐ YES ☐ NO

Do you plan to go swimming? ☐ YES ☐ NO

If yes: ☐ chlorinated pool ☐ Fresh water lake or stream ☐ Ocean

Do you plan to scuba dive? Certified? ☐ YES ☐ NO

MEDICATION AND ALLERGY INFORMATION

List current medications (including contraceptives and blood pressure medicine):_____

_____

_____

Please check if allergic to any of the following medications: ☐ Penicillin ☐ Azithromycin ☐ Cipro ☐ Sulfa ☐ Gentamycin ☐ Streptomycin ☐ Neomycin ☐ Polymixin ☐ Amphotericin B ☐ Other_____

Please check if allergic to any of the following vaccine components: ☐ Thimerisol/mercury ☐ Phenol ☐ Aluminum hydroxide ☐ 2-phenoxyethanol ☐ Formaldehyde ☐ Aluminum ☐ Chlortetracycline ☐ Other_____

Carden Dodson Medical Associates, LLC
1411 N. Flagler Drive, Suite 7900
West Palm Beach, FL 33401
Phone (561)655-8448

Name_____ Date of Birth_____

Question	Yes	No	Question	Yes	No
Do you have a medical condition that warrants regular medication or physician follow-up? If yes, please list:			Do you or any person you are in close contact with take cortisone, prednisone, steroids, chemotherapy (anti-cancer drugs) or radiation therapy?		
Do you have heart problems? Do you have a cardiac arrhythmia or irregularity?			Do you, or any person you are in close contact with, have cancer, leukemia, HIV/AIDS, or any other auto immune problem?		
Do you have high blood pressure? Are you on medication?			Do you have severe kidney problems?		
Do you have bleeding problems, take coumadin or blood thinners or aspirin?			Do you have G6PD deficiency? If yes, you should avoid certain anti-malaria medications		
Do you have lung disease, asthma, chronic bronchitis, emphysema, or shortness of breath?			Do you have an active nerve condition? Do you have a history of seizures or Gullian-Barre?		
Do you have a stomach or bowel condition, such as irritable bowel or frequent constipation or diarrhea? Do you use medication to reduce stomach acid?			Have you had your thymus gland removed, or problems with your thymus, such as myasthenia gravis, DiGeorge Syndrome or thymoma?		
Do you have any skin condition such as psoriasis, eczema or shingles?			Have you ever fainted from an injection or from having your blood drawn?		
Do you experience insomnia or nightmares?			Are you sick today?		
During the past three months, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin or Rho-gam?			Have you ever had a serious reaction after receiving a vaccination, such as hives, rash, wheezing, difficulty breathing, or shock?		
Do you have diabetes? If yes, do you take insulin? Yes____ No__			Do you have a history of depression or psychiatric disorders?		
Have you ever tested positive for tuberculosis?			Have you received any vaccinations in the past 4 weeks? If yes, please list:		
When at altitudes above 6,000 feet, have you ever had headache, dizziness or felt short of breath?			Women only: Are you pregnant or plan to get pregnant in the next 3 months?		
Have you had hives or urticaria?			Have you ever taken malaria pills? If yes, did you have any side effects?		

PREVIOUS IMMUNIZATIONS OR HISTORY OF THE DISEASE

Chicken Pox	Immune Globulin	Polio	Measles, Mumps, Rubella
Flu	Pneumonia	Menigitis	Tetanus/diphtheria/pertussis Hepatitis A
Hepatitis A	Hepatitis B	Rabies	Japanese Encephalitis
Yellow Fever	Typhoid	Cholera	

The above information is accurate to the best of my knowledge. I understand that insurance may not cover travel immunization services and I am responsible for all fees due at time of service. Payment is due at the time of service by credit card, cash or check. I understand that I will be given an immunization record with all vaccines received and that I am responsible for keeping this in a safe place and keeping records up to date.

Traveler/patient signature: _____ *Date:* _____

Travel Health Nurse: _____ *Date:* _____

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